PRINTED: 11/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001143	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY COMPLETED 10/05/2011	
NAME OF D	DOVIDED OD CUDDI IED		B. WING	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER  INDIANA ENDOSCOPY CENTERS					RONALD REAGAN PKWY STE	<b>!</b> (	
					IN46123		ave.
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
O0000							
	This visit was for a re-certification survey.  Facility Number: 003796		O0000				
	Survey Date: 10-3-11 - 10-5-11						
	Surveyors:						
	Jack I. Cohen, MHA						
	Medical Sur	veyor					
	John Lee, RN						
	Public Healt	h Nurse Surveyor					
	Tretter, Kari Public Healt	lyn, RN h Nurse Surveyor					
	QA: claughlin 1	0/25/11					
O0221	patient's represent notice of the patien date of the proced manner that the pa representative und Based on docume	ovide the patient or the tative with verbal and written int's rights in advance of the ure, in a language and atient or the patient's derstands. ent review and interview,	O0	221	The "Patients Rights" letter h been amended as of 11/3/11		11/03/2011
their i writte rights	their representati	ves with a verbal and garding exercising their ing subjected to			This amended page of this le (see attachement Q221) is no part of the patient packet mai to the patient and/or designal representive in advance of the date of procedure. The Clinic	ow iled ted ne	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

003796

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001143	ĺ	LDING	3 00		x3) date survey COMPLETED 10/05/2011	
NAME OF PROVIDER OR SUPPLIER INDIANA ENDOSCOPY CENTERS			STREET ADDRESS, CITY, STATE, ZIP CODE  1115 N RONALD REAGAN PKWY STE ( AVON, IN46123					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	Rights, which was their representation that patients or the exercise their right subjected to disconside the following the following the following prior to exit.  2. On 10-4-11 at interview, emplosabove-stated right	yee #A3 indicated the at was not given to the appresentative, either			Manager is responsible for ensuring that the language a content of the letter is kept updated.	nd		
O0222	place or places with noticed by patients applicable) waiting notice of rights muladdress, and teleprepresentative in the patients can report Web site for the Outlinessed on observations that patients could exercise the noticed by patients and patients.	notice of patient rights in a thin the ASC likely to be so (or their representatives, if for treatment. The ASC's set include the name, whone number of a the State agency to whom to complaints, as well as the fffice of the Medicare	O	0222	The posted written notice of patient rights had been amer as of 11/3/11. A copy of this notice is attached (Q222). To notice has been posted in the	his	11/03/2011	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001143		LDING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/05/2011	
NAME OF PROVIDER OR SUPPLIER INDIANA ENDOSCOPY CENTERS			STREET ADDRESS, CITY, STATE, ZIP CODE  1115 N RONALD REAGAN PKWY STE ( AVON, IN46123				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Rights, which was reception area, in patients or their exercise their rig	locument entitled Patient as posted in the facility's indicated it lacked that representatives could hts without being rimination or reprisal.			facility's waiting area as of 11/3/11. The Clinical Manage responsible for ensuring that language and content of the notice is kept updated.	t the	